

STATE OF NEBRASKA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Transition Plan to Implement the Settings Requirement for
Home and Community-Based Services Adopted by CMS on
March 17, 2014 for Nebraska's Home and Community-Based Waivers

DRAFT

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Summary

Effective March 17, 2014, the Centers for Medicare and Medicaid Services (CMS) issued new regulations that require home and community-based waiver services to be provided in community-like settings. The new rules define settings that are not community-like and cannot be used to provide federally-funded home and community based services. The purpose of these rules is to ensure that people live in the community and who receive home and community-based waiver services have opportunities to access their community and receive services in the most integrated settings. This includes opportunities to seek employment and work in competitive settings, engage in community life, control personal resources and participate in the community just as people who live in the community and do not receive home and community-based services do. The new rules stress the importance of ensuring that people choose service settings from options and are able to exercise rights and optimize independence. Services must reflect individual needs and preferences as documented by a person-centered plan.

History and Background

Medicaid is a program funded through a Federal and State partnership. Medicaid funds a variety of health related services including facility-based services that are considered institutional, such as those provided by skilled nursing facilities and Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD). In 1981, Section 1915(c) of the Social Security Act was established to allow states the opportunity to provide Medicaid funded services to people in their own homes and communities as an alternative to institutional care.

Since that time, home and community based services have been provided in a wide variety of settings, many of which are truly integrated in the community. Some of these settings, however, may retain or appear to retain, the qualities of institutional care. To ensure home and community-based services offer a true option to institutional care, the Centers for Medicare and Medicaid Services (CMS) proposed regulations to better define settings in which states can provide Medicaid home and community based services (HCBS):

- June 29, 2009: CMS published an advance notice of proposed rulemaking (ANPRM) that indicated intent to initiate rulemaking related to the program that provides funding for Nebraska's home and community based services.
- April 15, 2011: CMS published the Notice of Proposed Rule Making (NPRM) that addressed issues raised in the ANPRM.
- January 16, 2014: After considering extensive public comments, CMS published the final rule which became effective March 17, 2014.

The New CMS HCBS Rules

The new CMS HCBS rules set expectations for settings in which HCBS can be provided. In response to comments received during the rule making process, CMS moved away from defining these settings based on specific characteristics. The final rule requires that “community-like” settings be defined by the nature and quality of the experiences of the individual receiving services and applies to both residential and day services settings.

In all settings, the rule requires that:

- The setting is selected by the individual from options that include non-disability specific settings and options for privacy in residential settings (i.e. a private room or unit.) Individuals must have choice of providers, services and settings and that choice must be documented by a person-centered plan.
- Each person has the right to privacy, is treated with dignity and respect and is free from coercion and restraint.
- People have optimal opportunity for independence in making life choices without regimented daily activities, can access their physical environment and may interact with family and friends, just as people who are not receiving home and community based services do.

In residential settings owned or controlled by a service provider, additional requirements must be met:

- Each individual must have the same responsibilities and protections from eviction that tenants have under state or local landlord/tenant laws. If such laws do not apply, a lease or other legally binding agreement is in place to provide those protections.
- Each individual must have privacy in their sleeping or living unit, with a lock and key controlled by the individual and appropriate staff.
- Individuals must be allowed to furnish and decorate their own sleeping and living areas, to have access to food at any time, and to have visitors of their choosing at any time.
- Individuals sharing a living unit must have choice of roommate.

These requirements may only be modified if the individual has a need that justifies deviation that is documented in the individual’s person-centered plan.

The rule clarifies settings in which home and community based services cannot be provided. These settings include: hospitals, skilled nursing facilities, institutions for mental disease and intermediate care facilities.

The rule also defines settings that are “likely not” community. CMS requires states to provide justification that these settings are not institutional in nature. Justification must include input from the public. CMS requires approval of settings that fall in to one or more of the following categories:

- *“Any setting that is located in a building that is publicly or privately operated facility that provides inpatient institutional treatment;*
- *A building on the grounds of, or immediately adjacent to, a public institution; or*
- *Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.”*

Transition Plan Requirements

The new CMS rules require states to submit a transition plan within one year of the March 17, 2014, effective date. The transition plan must describe the process by which the state will ensure that service settings used in each of its home and community based waivers meet community-like expectations. States may be granted a maximum of five years to transition settings that are not compliant.

States that are in the process of amending or renewing a waiver must submit a transition plan with the waiver amendment or renewal. Within 120 days of submitting an amendment or renewal, the state must submit, for CMS approval, a comprehensive transition plan for all waivers. The plan must be available for public comment for a period of at least 30 days and be available from a minimum of two forms of public notice. Both forms of public notice should reach individuals receiving services and the full cadre of stakeholder. The state’s transition plan submission to CMS must include a summary of public comment that includes how issues will be addressed. The transition plan, with any revisions based on public comment, must be made available publicly.

Nebraska’s Transition Plan

Nebraska’s Department of Health and Human Services (DHHS) has initiated a comprehensive review of Nebraska’s HCBS waivers and related regulations, policy and procedures to assess and identify changes necessary to comply with the new CMS HCBS rules and ensure people receiving long term services and supports have the same opportunity to access their community that all Nebraska’s citizens enjoy. The services currently under review include home and community-based waiver services administered by the Division of Medicaid and operated by the Division of Medicaid and Long Term Care and the Division of Developmental Disabilities, as follows:

The Division of Developmental Disabilities:

1. Developmental Disabilities Comprehensive Waiver at http://dhhs.ne.gov/developmental_disabilities/Documents/Nebraska-DDAC-waiver-2011.pdf
2. Adult Day Waiver at http://dhhs.ne.gov/developmental_disabilities/Documents/Nebraska-DDAD-waiver-2011.pdf
3. Children and Families Waiver

Developmental Disabilities Rules and Regulations can be found in Title 404 of the Nebraska Administrative Codes at http://dhhs.ne.gov/Pages/reg_t404.aspx

The Division of Medicaid and Long-Term Care:

1. Aged and Disabled Waiver at http://dhhs.ne.gov/Pages/hcs_programs_ad-waiver.aspx
2. Traumatic Brain Injury Waiver at http://dhhs.ne.gov/Pages/hcs_programs_tbi-waiver.aspx

Medicaid and Long Term Care Rules and Regulations can be found in Title 480 of the Nebraska Administrative Code at http://dhhs.ne.gov/Pages/reg_medregs.aspx

The Transition Plan Matrix/Matrices

The DHHS has created a comprehensive long term services and supports transition plan which is outlined in the Comprehensive Transition Plan Matrix included herein and that:

- Identifies waiver program areas for further analysis;
- Engages system stakeholders in evaluation of those areas; and
- Establishes time frames for assessment and remediation of areas that do not meet the expectation of “community-like.”

This plan is posted on the DHHS website and is available for public comment from the period of 09/03/14 – 10/15/14. Interested parties may comment by:

- Emailing to DHHS.HCBSPublicComments@nebraska.gov;
- Faxing to 402-471-9449 attention Christina Mayer;
- Mailing written comments to the Department of Health and Human Services, Attention: Christina Mayer, 301 Centennial Mall South, P.O. Box 95026, Lincoln, NE 68509-5026;
- Providing in person comments at public meetings; and/or
- Calling Christina Mayer at 1-877-867-6266.

As this plan may be approved in its entirety or may be severable into two separate plans (as described in the next section), all comments will be categorized upon receipt into the following categories:

- Comprehensive (applies to all waivers);
- Developmental Disability Division Managed Waivers (to include all developmental disability HCBS waiver services);
- Medicaid and Long-Term Care Managed Waivers (to include the Aged and Disabled Waiver and Traumatic Brain Injury waivers).

The DHHS will host public meetings to provide an overview of the new CMS HCBS rules and receive public comments on the transition plan. A general overview of the new HCBS rules will be provided at each meeting and copies of this transition plan will also be available. Other than the meeting scheduled for Lincoln on September 30, 2014, however, the meetings will be targeted to specific waiver populations. The following table identifies the location of each meeting and the waiver-specific presentations.

City	Date/Time	Location	Waiver-Specific Presentations
Kearney	Sept. 29, 2014; 1:00 – 3:00 p.m. CDT	Niobrara Room, Kearney Public Library, 2020 1 st Avenue	Developmental Disability Managed Waivers
Lincoln	Sept. 30, 2014; 1:00 – 4:30 p.m. CDT	Lower Level B, Nebraska State Office Building, 301 Centennial Mall South	All Waivers Will Be Presented
Omaha	Oct. 7, 2014; 9:00 a.m. CDT	Metro Community College, 5330 North 30 th St, Building 10 Room 110	Medicaid & Long Term Care Managed Waivers
Sidney	Oct. 9, 2014; 9:00 a.m. MDT	Western Nebraska Community College, Room 115, 371 College Dr.	Medicaid & Long Term Care Managed Waivers

Severability

While the DHHS would prefer to implement this plan in its entirety, if for any reason there is a delay related to either the Division of Developmental Disabilities managed waivers or the Division of Medicaid and Long-Term Care Managed Waivers, this plan may be severed to ensure timely implementation of the plan with regard to the division managed waivers not impacted by the delay. Delay may be caused by DHHS determining that substantive changes need to be made due to public comment, new CMS guidance, or other reasons as determined by each division director. For this reason, and to simplify review of the plan for stakeholders, the plan is being presented in a Comprehensive Matrix, a Medicaid and Long-Term Care Managed Waivers Matrix (which is applicable to the Aged and Disabled Waiver and the Traumatic Brain Injury Waiver) and a Division of Developmental Disabilities Managed Waivers Matrix (which is applicable to all three developmental disability waivers).